

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K033	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2014
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NAME OF PROVIDER OR SUPPLIER ANOINTED TOUCH HOME HEALTH LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2021 E 52ND ST STE 100 A-E INDIANAPOLIS, IN 46205
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G000000	<p>This visit was a home health agency federal recertification survey.</p> <p>Facility #: 011457</p> <p>Survey Date: March 26 - 27, 31 and April 1-2, 2014 Partial Extended Survey Dates: March 31, 2014</p> <p>Provider #: 15K033</p> <p>Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 12 Home Health Aide Only: 33 Personal Care Only: 0 Total: 45</p> <p>Sample: RR w/HV: 5 RR w/o HV: 5 Total: 10</p>	G000000		
G000159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>appropriate items.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the Plan of Care (POC) contained all pertinent diagnoses in 1 of 10 clinical records reviewed with the potential to affect all patients receiving services from the agency. (#1)</p> <p>Findings include:</p> <p>1. The policy titled "Plan of Care" undated states, "The Plan of Care shall be completed in full to include: a. All pertinent diagnosis(es), principle and secondary, including dates of onset."</p> <p>2. Clinical record #1, Start of Care (SOC) 1/27/14, contained a Home Health Certification and Plan of Care (POC) dated 1/27/14 - 3/27/14. The record evidenced the following:</p> <p>A. The POC dated 1/27/14 - 3/27/14 indicated open wound anterior abdomen as the principal diagnosis.</p> <p>B. The Comprehensive Adult Nursing Assessment dated 1/27/14 indicated Congestive Heart Failure as the primary diagnosis.</p> <p>C. The record failed to evidence the same principal / primary diagnosis on the POC and the Comprehensive Adult Nursing Assessment.</p> <p>3. During an interview on 3/31/14 at 4:17 PM, employee A, Administrator, acknowledged</p>	G000159	<p>1.The deficiency was actually corrected on the next certification period. The plan of care and the comprehensive assessment were in agreement. The Administrator had noticed this on an audit and began reviewing charts as of March 2014 for this deficiency. Most charts have been reviewed, but all charts will be reviewed and corrected by April 30, 2014. Clarification orders will be written if needed and sent to the physicians.</p> <p>2.To prevent the deficiency from recurring in the future the quality assurance program has implemented a Briggs assessment and plan of care audit tool to ensure that the plan of care and the comprehensive assessment are in agreement. The Director of Nursing or RN Designee will in-service all nursing staff on the use of this tool and the importance of making sure that the POC and comprehensive assessment are in agreement. Ten percent of clinical records will be audited monthly to ensure compliance. Monitoring will be on-going.</p> <p>3.The Director of Nursing or RN Designee will be responsible for overseeing the corrective action on an on-going basis.</p> <p>4.All in-servicing and audits will be completed by April 30, 2014. Chart referenced in deficiency has been corrected.</p>	04/03/2014			

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G000337	<p>the primary diagnosis on the SOC Comprehensive Adult Nursing Assessment did not match the principal diagnosis on the POC.</p> <p>484.55(c) DRUG REGIMEN REVIEW</p> <p>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the Registered Nurse (RN) updated the Medication Profile in 3 of 10 clinical records reviewed with the potential to affect all patients of the agency. (#1, #2, #3)</p> <p>Findings Include:</p> <p>1. The policy titled "Medication Profile" undated states, "The Medication Profile shall be reviewed and updated by a Registered Nurse at least every 60 days and whenever there is a change or discontinuation in medication. The Registered Nurse shall sign and date the Medication Profile upon initiation and, at minimum, every 60 days thereafter."</p> <p>2. Clinical record #1, Start of Care (SOC) 1/27/14, contained a Medication Profile with Prolensa and Ketotifen Fumarate added on 3/7/14. The record failed to evidence the RN reviewed the Medication Profile on or after 3/7/14.</p>	G000337	<p>1. For each patient cited on the plan of correction, late entries were documented and shown as reviewed on the medication profiles. The registered nurses were reviewing and adding and discharging medications, however, failing to sign as reviewed on the medication profile sheets. All client charts are being reviewed for updated med profile entries, by late entry and will be completed by April 30, 2014.</p> <p>2. To prevent the deficiency from recurring, the Director of Nursing will in-service all nursing staff on properly updating the medication profiles when there is a change or discontinuation in medication. Ten percent of all clinical medication profiles will be audited monthly to ensure compliance. Monitoring will be on-going.</p> <p>3. The Director of Nursing or RN Designee will be responsible for monitoring the corrective action.</p>	04/30/2014			

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N000000	<p>3. Clinical record #2, SOC 7/4/11, contained a Medication Profile with Lasix added on 3/11/14. The record failed to evidence the RN reviewed the Medication Profile on or after 3/11/14.</p> <p>4. Clinical record #3, SOC 12/12/11, contained a Medication Profile with Spironolactone added on 3/2/14. The record failed to evidence the RN reviewed the Medication Profile on or after 3/2/14.</p> <p>5. During an interview on 4/2/14 at 1:03 PM, employee B, Director of Nursing, indicated the Registered Nurse needed to review the Medication Profile whenever a new medication was added.</p> <p>This visit was a home health agency state relicensure survey.</p> <p>Facility #: 011457</p> <p>Survey Date: March 26 - 27, 31 and April 1-2, 2014</p> <p>Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 12 Home Health Aide Only: 33 Personal Care Only: 0 Total: 45</p> <p>Sample: RR w/HV: 5 RR w/o HV: 5</p>			N000000	<p>4. All medication profiles will be audited and updated by April 30, 2014. All nurses will be in-serviced by April 30, 2014.</p>		

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N000524	<p>Total: 10 410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following:</p> <p>(i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the Plan of Care (POC) contained all pertinent diagnoses in 1 of 10 clinical records reviewed with the potential to affect all patients receiving services from the agency. (#1)</p> <p>Findings include:</p> <p>1. The policy titled "Plan of Care" undated</p>	N000524	<p>1.The deficiency was actually corrected on the next certification period. The plan of care and the comprehensive assessment were in agreement. The Administrator had noticed this on an audit and began reviewing charts as of March 2014 for this deficiency. Most charts have been reviewed, but all charts will be reviewed and corrected by April 30, 2014. If clarification orders are needed they will be sent to the MD. 2.To prevent the deficiency</p>	04/30/2014			

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N000597	<p>states, "The Plan of Care shall be completed in full to include: a. All pertinent diagnosis(es), principle and secondary, including dates of onset."</p> <p>2. Clinical record #1, Start of Care (SOC) 1/27/14, contained a Home Health Certification and Plan of Care (POC) dated 1/27/14 - 3/27/14. The record evidenced the following:</p> <p>A. The POC dated 1/27/14 - 3/27/14 indicated open wound anterior abdomen as the principal diagnosis.</p> <p>B. The Comprehensive Adult Nursing Assessment dated 1/27/14 indicated Congestive Heart Failure as the primary diagnosis.</p> <p>C. The record failed to evidence the same principal / primary diagnosis on the POC and the Comprehensive Adult Nursing Assessment.</p> <p>3. During an interview on 3/31/14 at 4:17 PM, employee A, Administrator, acknowledged the primary diagnosis on the SOC Comprehensive Adult Nursing Assessment did not match the principal diagnosis on the POC.</p> <p>410 IAC 17-14-1(l)(1)(B) Scope of Services Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry.</p> <p>Based on personnel file review and interview, the agency failed to ensure the Home Health</p>	N000597	<p>from recurring in the future the quality assurance program has implemented a Briggs assessment and plan of care audit tool to ensure that the plan of care and the comprehensive assessment are in agreement. The Director of Nursing or RN Designee will in-service all nursing staff on the use of this tool and the importance of making sure that the POC and comprehensive assessment are in agreement, and that all principal diagnosis are correct. Ten percent of clinical records will be audited monthly to ensure compliance. Monitoring will be on-going.</p> <p>3. The Director of Nursing or RN Designee will be responsible for overseeing the corrective action on an on-going basis.</p> <p>4. All in-servicing and audits will be completed by April 30, 2014. Chart referenced in deficiency has been corrected.</p> <p>1. To correct this deficiency the agency submitted an application to the State registry to have the employee entered on the State aide registry. Many of our</p>	04/07/2014			

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	<p>Aide (HHA) was entered on and in good standing on the state aide registry in 1 of 2 HHA personnel files reviewed (C) with the potential to affect current patients that receive home health aide services.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> 1. Personnel File C, date of hire of 7/19/12, failed to evidence the agency had checked to ensure the aide was entered on and in good standing on the state home health aide registry. 2. During an interview on 4/2/14 at 11:55 AM, employee A, Administrator, indicated employee C was not on the registry. Employee A further indicated she thought employee C was on the registry and must have overlooked this. 		<p>employees are duly certified and this employee's CNA license was mistaken for HHA license. The employee now has her certification and her new HHA license is currently on file and in good standing.</p> <ol style="list-style-type: none"> 2. To ensure the deficiency will not recur the Administrator will also audit ten percent of personnel files monthly to ensure that the employees are properly registered with the aide registry. Personnel files are also audited on an on-going basis quarterly. 3. The Administrator will be responsible for on-going monthly monitoring. 4. The deficiency was corrected by April 9, 2014. 	